



Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #:	M4-10-4962-01
	DWC Claim #:	
	Injured Employee:	
Respondent Name and Box #: STATE OFFICE OF RISK MANAGEMENT Box #: 45	Date of Injury:	
	Employer Name:	
	Insurance Carrier #:	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "You fail to pay a legitimate claim. I want the bill paid and all penalties allowed by law for this grievance against me, the employee!"

Principle Documentation:

1. DWC 60 package
2. Receipts
3. Amount in Dispute: \$216.60

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "It appears after a thorough review of the dispute that the injured worker is filing for dispute on behalf of the health care provider... The Injured employee has failed to submit proof of employee payment of health care services by submitting copies of the carrier's denial of reimbursement or refund relevant to the dispute. Therefore this dispute is incomplete..."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
04/21/2009	N/A	Out-of-Pocket Expenses	\$216.60	\$0.00
Total Due:				\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.270 sets out the procedures for injured employees to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §133.270 sets out the procedures for injured employees to submit workers' compensation medical bills for reimbursement.
3. 28 Tex. Admin. Code §133.270 sets out the fee guidelines for the reimbursement of the out-of-pocket expenses incurred by the injured employee for their workers' compensation injury.

Issues

1. Did the requestor submit the request for medical dispute resolution timely in accordance with 28 Tex. Admin. Code §133.307?
2. Did the requestor incur out of pocket expenses?
3. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Admin. Code Section §133.307(c)(1)(A) the request for medical fee dispute resolution was received by the Division on July 27, 2010; the date of service in dispute is April 21, 2009. Therefore, this dispute was not submitted in a timely manner.
2. The requestor was contacted in regards to this dispute as there was no information submitted with the dispute showing the injured employee had paid for treatment/services. The injured employee did not incur out of pocket expenses for the date of service in dispute. In accordance with 28 Texas Admin. Code Section §133.307(e)(3)(B) the injured worker is not a proper party to the dispute pursuant to subsection (b) of this section.
3. **Conclusion** For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Texas Administrative Code Sec. §133.270

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to \$0.00 reimbursement.

September 16, 2010

Authorized Signature

Auditor III
Medical Fee Dispute Resolution

Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.